STUDENT ACCIDENT COVERAGE

How to File a Claim

CLAIM FORM

- **A school official must complete and submit the Claim Form to the ISDA Claims Administrator no later than 90 days after the date of injury. "School Official" includes a teacher, school principal, president, chancellor, board member, trustee, registrar, counselor, admissions officer, attorney, accountant, human resources professional, information systems specialist, and support or clerical personnel.**

- **A school official reports Student Accident claims using the secure Claims Portal at:**

  https://portal.sandnergroup.com/brpsweb/cmlogin.pgm

- A School Official may also report Student Accident claims via email at **SAClaims@one80.com** or by U.S. Mail to the following address:
  ISDA c/o Student Accident Claims Administrator
  333 West Wacker Drive, Suite 1200
  Chicago, Illinois 60606

ITEMIZED BILLS and EOBs

- Instruct your medical provider to submit itemized bills to your primary medical coverage provider, and to the ISDA Claims Administrator. You will receive an Explanation of Benefits (EOB) from your primary medical coverage provider or claims administrator (Blue Cross, Group Health, Prudential Insurance, etc.) after they have processed your claim.

- **Itemized bills and EOBs (samples attached) must be submitted to the ISDA Claims Administrator immediately as you receive them, but no later than 180 days after the date of treatment.** Itemized bills include (1) CMS-1500 (physician/ancillary charges) and (2) UB04 (hospital charges). All bills must include the patient's name, date of service, total charge, procedure and diagnosis codes, and the provider's tax identification number. **Balance due, balance forward, or past due statements are not bills and will not be processed.**

- **Submit itemized bills and EOBs via email: SAClaims@one80.com** or by U.S. Mail to: Student Accident Claims, ISDA Claims Administrator 333 West Wacker, Suite 1200 Chicago, IL 60606.

- Payment will be made to the provider(s) of service (hospital, physician, radiologist, etc.) unless a paid receipt or statement from the provider accompanies the itemized bill showing the bill was paid. If you already paid the bill(s), include the receipt or a copy of your cancelled check.

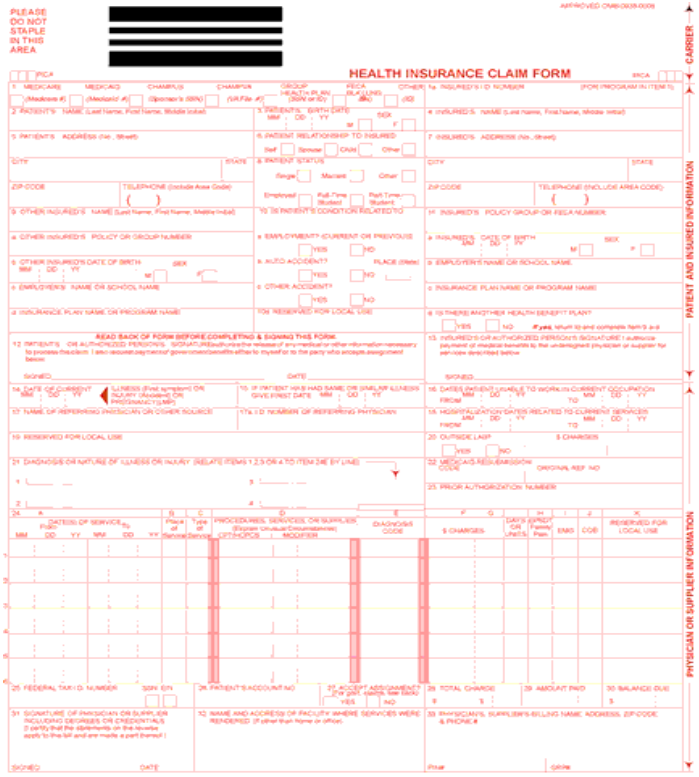
GENERAL INFORMATION

- Students must be treated by a licensed medical provider **within 30 days** from the covered injury date.

- This Plan is **EXCESS** to all other valid coverage. Your primary coverage **MUST** provide payment first and before Student Accident benefits are considered for payment. Benefits under the Student Accident Coverage Plan are not guaranteed. Upon receipt of acceptable, complete, and timely itemized bills and EOBs, benefits will be determined in accordance with the Plan.

- Further information is available in the Student Accident Coverage brochure available at https://wcsit-isda.com/the-trusts/isda/student-accident or at (800) 419-3206.

SAMPLE HCFA 1500


PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED | DATE | SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED | DATE | PIN# | GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OMB-0938-0008

CARRIER

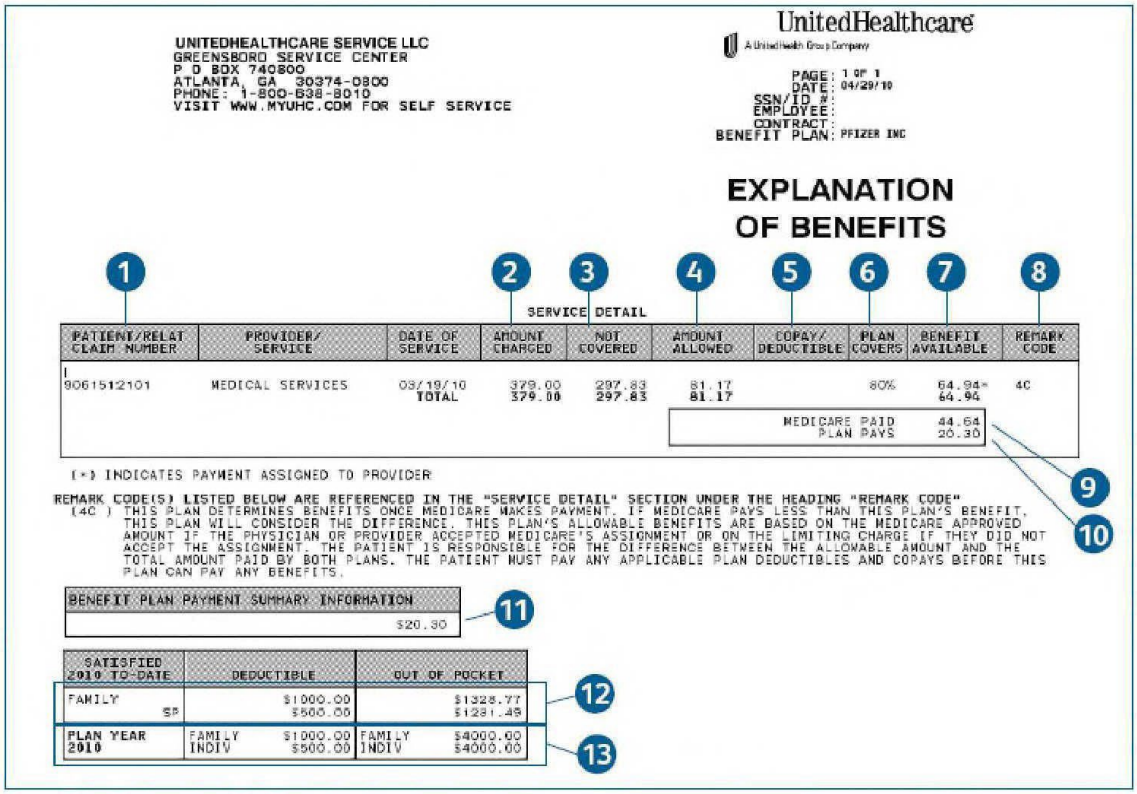
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE UB-04


PAGE OF CREATION DATE TOTALS

SAMPLE EOB (EXPLANATION OF BENEFITS)


UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA GA 30374-0800
PHONE: 1-800-638-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 04/29/10
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

SERVICE DETAIL

1 PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	2 DATE OF SERVICE	3 AMOUNT CHARGED	NOT COVERED	4 AMOUNT ALLOWED	5 COPAY/ DEDUCTIBLE	6 PLAN COVERS	7 BENEFIT AVAILABLE	8 REMARK CODE
9061512101	MEDICAL SERVICES	03/19/10	379.00	297.83	81.17		80%	64.94*	4C
	TOTAL		379.00	297.83	81.17			64.94	
							MEDICARE PAID	44.64	
							PLAN PAYS	20.30	

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION
$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE	OUT OF POCKET
FAMILY	$1000.00	$1328.77
SP	$500.00	$1231.49
PLAN YEAR 2010	FAMILY $1000.00	FAMILY $4000.00
	INDIV $500.00	INDIV $4000.00

9 10 11 12 13